**Wellbeing Single Point Referral Form   
Secure Email referral to: chcp.sthelens@nhs.net**

**Part One: Patient Information**

**Patient Information Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NHS Number** | **Name** | | | | | |
| 00000 000 000 | Title | | Forename | | Surname | |
| **Date of Birth** | **Gender** | | | **Ethnicity** | | |
| Date of Birth | Gender | | | Ethnicity | | |
| **GP Name** | | **GP Practice Address** | | | | **GP Practice Code** |
| GP Name | | GP Practice Address | | | | GP Practice Code |

**Patient Contact Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Phone** | **Mobile** | **Email** | | |
| 00000 000 000 | 00000 000 000 | Email | | |
| **Address** | | | | **Postcode** |
| Address | | | | Postcode |
| **(If patient under 18yrs) Parent / Carer Full Name** | | | **Contact** | |
| Parent / Carer Full Name | | | 00000 000 000 | |

**Referrer Details**

|  |  |
| --- | --- |
| **Referrer Name** | **Referrer Job Title** |
| **Referrer Name** | **Referrer Job Title** |
| **Referrer Address (if different to above)** | |
| Referrer Address | |

**Patient Medical Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Height** | **Weight** | **BMI** | **Date of last measurements** | |
| Height in cm | Weight in kg | BMI | Date of last measurements | |
| **Blood Pressure** | | **Resting Heart Rate** | | |
| 000 / 000 | Date of reading | Resting Heart Rate | Date of reading | |
| **HbA1c or Fasting Glucose** | | **TFTs** | | |
| HbA1c mmol/L | Date of reading | TFTs | Date of reading | |
| **Full lipid profile** | **Cholesterol** | **HDL** | **LDL** | **Triglycerides** |
| Date of test | Cholesterol | HDL | LDL | Triglycerides |

**Additional Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Communication** | **Contact** | **Format** | **Professional** | |
| **Communication Needs** | Please select | Please select | Please select | Please select | |
|  | | | | |
| Please include any relevant additional patient / medical information, including any special requirements, that we need to be aware of to enable the patient to engage with our services | | | | |

**Where all information is not known, please send through to GP to make a referral. Attach separately any concerns or further information to be included about the patient’s situation, medical details, and current medication to help facilitate their wellbeing plan.**

**Part Two: Referral Information**

**St Helens Wellbeing provide a range of services and support for individuals and families. Please discuss with the patient and indicate below which support they are to be referred:**

|  |  |  |
| --- | --- | --- |
|  | **Get Active / Exercise** | General exercise advice and activities for all the family through to specialist exercise advice for a range of health conditions |
|  | **Alcohol Reduction** | Support for patients with an **AUDIT score of 15 and under** (Lower to Increasing Risk) |
|  | **Infant Feeding** | Birth+ - Breastfeeding / Infant Feeding Support  4 - 12 months - Introducing Solid Foods Education  1-4 years - Eating Well Programme |
|  | **Diabetes Prevention** | Aged 18 and over with **HbA1c 42-47 mmol/L** or FPG 5.5-6.9 mmol/L **within last 12 months** or history of **Gestational Diabetes Mellitus**. Service delivered by Reed Wellbeing |
|  | **Healthy Eating** | Guidance around basic food, nutrition, portion sizes following the Eatwell Guide |
|  | **Social Prescribing** | Holistic approach to help clients with navigating support for finance issues, housing, employment, loneliness / isolation as well as physical health and wellbeing improvements |
|  | **Stop Smoking** | Specialist stop smoking support for smokers aged 12 and over |
|  | **Weight loss / Obesity Management** | **General Weight Management**  Support for adults looking to achieve a healthy weight and improved lifestyle through healthy eating and exercise advice.  **Tier 3 Specialist Weight Management**  **Adults**: BMI >35 with co-morbidities; BMI >40 or BMI >30 with Type 2 Diabetes or pregnant   * Patient meets the full acceptance criteria for referral * Patient wants to be considered for bariatric surgery; check if referrer is in agreeance * Patient is aware the service *does not* prescribe medication, including for weight loss   **Children**: >98th Centile (bloods not required)  **Blood test results and physiological measurements (recorded within Patient Medical Information) must be within the last 3 months** |

By referring this patient to the Wellbeing Service, as part of their intervention they may be offered a programme of exercise. **Please indicate if** **patient is clinically unsuitable for an exercise intervention:**

**Confirmation**

**In signing below, as the patient’s referrer, I confirm that:**

* **The Wellbeing Services offer has been discussed with the patient and they consent to be referred**
* **The patient agrees to be contacted via phone, SMS text message or email**

|  |  |
| --- | --- |
| **(Digital) Signature of referring clinician** | **Date of referral** |
| Referrer Signature | Date |